STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

FINAL REPORT OF THE ROUTINE MEDICAL SURVEY

CARE 1st HEALTH PLAN

Issued to Plan: February 15, 2002
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I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a medical survey of each licensed health care service plan ("Plan") at least once every three years. The medical survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] Generally, the subjects of the survey fall into the following categories:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits; and
- Overall performance of the plan in meeting the health needs of enrollees:

Care 1st Health Plan (the Plan) submitted pre-survey documents to the Department on August 4, 2001. The on-site review was conducted on August 27-30, 2001. As part of the survey process, the survey team conducted interviews and examined documents at the Plan 's administrative offices in Alhambra, California and at the offices of five of the Plan's contracting Independent Practice Associations (IPA) and medical groups (MG). The participants of the survey team and names of persons who were interviewed at the Plan and at each medical group are listed in Appendices A, B, and C respectively in this report. The medical groups were selected based upon one or a combination of factors: the number of Plan enrollees served by the IPAs or medical groups, incidence of complaints/grievances filed by Plan enrollees and the number of overturned appeals by the Plan per 1,000 Plan enrollees. The medical groups surveyed were:

- Asian Community Medical Group
- Preferred IPA
- Cal Care Medical Group
- University Affiliates IPA
- Crown City Medical Groups

The Preliminary Report of the survey findings was sent to the Plan on October 29, 2001. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted its response on December 18, 2001.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43. ("the Rules")].

Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. If the plan wishes to append its response to the Preliminary Report to the Final Report please notify the Department before February 25, 2002

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after February 25, 2002. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. Final Reports will be available on the Department's web site: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan and will issue a follow-up report within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Finally, Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

II. OVERVIEW OF ORGANIZATION AND HEALTHCARE DELIVERY SYSTEM

Date Plan Licensed: 1995

Type of Plan: Full service health care service plan.

For profit / Non-profit Status: For profit

Service Area(s): Los Angeles County

Number of Primary Care Physicians: Approximately 1,351

Number of Specialty Physicians: Approximately 2,271

Number of Enrollees as of Date of Survey: Approximately 87,017

Product Type	Enrollees
Commercial	0
Medicare	0
Medi-Cal	83,195
Healthy Families	2,236
Medi-Cal Dental	1,586
Total	**87,017**

History and Organization Structure

Care 1st Health Plan was established as a privately held for-profit California corporation in 1994 and received its Knox-Keene license in 1995 as a full service health care plan.

In 1995, Care 1st became a "Plan Partner" of LA Care, the local initiative Health Plan for Los Angeles County established under the State Two-Plan Model for Medi-Cal Managed Care. Care 1st entered into a Service Agreement with LA Care to provide health care services to eligible Medi-Cal enrollees. Today, Care 1st provides health care services to over 80,000 Medi-Cal enrollees within the Los Angeles County under this agreement.

In 1998, Care 1st entered into a Global Services Agreement with LA Care to provide covered services to eligible Healthy Families Program (HFP) children. Services under this agreement were provided until the termination of the contract in 2001.

In 2000, Care 1st received its own direct contract from the administrator of the Healthy Families Program, Managed Risk Medical Insurance Board (MRMIB), a state board created in 1990 to improve

the health care status of Californians and reduce the number of uninsured persons in the state. Under its current agreement with MRMIB, Care 1st provides care for over 2000 HFP children.

In year 2000, Care 1st also contracted with the Department of Health Services Dental (DHS- Dental) to provide dental services to eligible Medi-Cal enrollees. Currently, Care 1st provides care for over 1,500 enrollees under the Medi-Cal dental services program.

The Plan has increased its Medi-Cal and Healthy Families enrollment over its last five (5) years of operation. The Plan is currently in the process of bringing on additional enrollees through a possible acquisition of 80,000 Maxicare Medi-Cal enrollees. This acquisition will double the enrollee population to over 160,000.

The Plan operates as a mixed model HMO contracting directly with IPA/MGs and individual physicians to provide services on a capitated (fixed amount) basis. The Plan is delegated by LA Care the following managed care functions: **(1)** utilization management, **(2)** quality management, **(3)** grievances and appeals, and **(4)** credentialing. Care 1st, in turn, subdelegates utilization management and credentialing functions to its contracted IPAs/MGs and provides oversight for these functions. Quality management and appeals/grievance functions are not subdelegated.

Delivery Model

Enrollees select primary care physicians (PCP) who belong to contracting Independent Practice Associations and Medical Groups (IPA/MG) or are independently contracted physicians within the Plan's service area. The Plan pays a fixed ("capitated") amount to the contracting IPAs and Medical Groups and individual physicians based upon the number of the Plan enrollees. It pays specialists with whom it contracts directly on a discounted fee-for-service basis. Enrollees access all non-emergency health care services through their selected PCP.

Contracting Providers/Enrollment

The Plan has 24 contracting provider groups – 8 IPAs and 16 MGs. Twenty-one of these contracts are shared-risk, 3 are full-risk. The Plan shares risk for inpatient services, nursing home care, home health services and hospice services. This IPA/MG network accounts for 80 percent of the Plan's providers; Care 1st's direct contracts with primary care providers (PCPs) account for the remaining 20 percent. An estimated 75% of the enrollees chose IPA/MG providers and 25% is with direct contract providers.

Listed below are the 24 contracting IPAs/MGs showing their risk arrangement with Care 1st and ranked in descending order based upon enrollment data:

IPA / MEDICAL GROUP	Shared Risk	Full Risk	Enrollment
Preferred IPA	X		11,609
University Affiliates IPA	X		10,658
Cal Care Medical Group	X		5,037
Crown City Medical Group	X		4,773

IPA / MEDICAL GROUP	Shared Risk	Full Risk	Enrollment
Los Angeles Medical Center	X		4,389
Pacifica Alliance Medical Group	X		3,432
Physicians Healthway Medical Group	X		2,651
Asian Community Medical Group		X	2,440
Allied Physicians of California	X		2,424
Angeles IPA	X		2,153
San Miguel IPA	X		2,099
La Vida Medical Group	X		1,920
Global Care IPA	X		1,493
St. Peter Medical Group	X		1,254
Serra Medical Group	X		1,117
Cal Pacific Physician Medical Group		X	1,037
Advantage Health Network		X	1,013
Accountable Health Plan IPA	X		928
Southland San Gabriel Medical Group	X		892
Healthcare LA IPA	X		888
Southern California Medical Group	X		841
Bella Vista Medical Group	X		746
Mission Community IPA	X		709
Harvard Healthcare Medical Associates	X		386
Total			**64, 889 (75%)**

NUMBER OF PRIMARY CARE PRACITITIONERS

TYPE OF PRACTITIONERS	NUMBER OF PRACTITIONERS	EST. % OF ENROLLMENT
IPA/MG Primary Care Physicians	1172	75%
Direct Contract Primary Care Physicians	179	25%
Total	**1351**	**100%**

NUMBER OF SPECIALTY CARE PRACTITIONERS

TYPE OF PRACTITIONERS	NUMBER OF PRACTITIONERS	EST.% OF ENROLLMENT
IPA/MG Specialty Care Physicians	1820	N/A
Direct Contract Specialty Care Physicians	451	N/A
Total	**2271**	

NUMBER OF INSTITUTIONAL AND ANCILLARY PROVIDERS

TYPE OF PROVIDERS	NUMBER IN NETWORK	REIMBURSEMENT METHOD
Acute Care Facilities/Hospitals	60	Discounted off charges, FFS, Per Diems
Sub-Acute Care Facilities		
Skilled Nursing Facilities	1	Per Diem
Home Health Agencies	22	Discounted FFS
Free-Standing Ambulatory SurgiCenter	1	Discounted FFS
Other: ancillary (lab, DMEs, etc.)	184	Discounted FFS

Arrangements for Specialty Care

Each IPA/MG contracts directly with specialty providers to provide specialty health care services to the Plan's enrollees who have selected PCPs who are members of the IPA/MG. Enrollees must obtain referrals from their PCPs in order to obtain access to specialists contracting with the IPA/MG. Prior authorization for specialty referrals from the IPA/MG is required.

Behavioral health is carved out for Medi-Cal members and the county mental health system is currently being used for the relatively few Healthy Families enrollees.

Arrangements for In-patient Care

With the exception of the three (3) full risk medical groups, (Asian Community Medical Group, Cal Pacific Physician Medical Group, Advantage Health Network) which have their own contracts with hospitals, the Plan has three (3) types of contract arrangements with sixty (60) acute care providers. These arrangements include per diem, fee for service, or discounted billed charges type contracts. Enrollees are directed to these hospitals by their PCPs. The Plan shares risk for inpatient services with the other remaining twenty-one (21) IPA/MGs. Enrollees with these 21 IPA/MGs are directed to contracted acute care hospitals associated with their respective IPA/MG.

Arrangement for Emergency Care

Enrollees may seek emergency care from any emergency provider without prior authorization. The IPA/MG assumes risk for ER services within its service area (*in-area*). The Plan assumes risk for out of area ER services.

Risk Assumption for Health Care Services (Who Pays?)

Generally, the Plan's risk arrangement with contracting IPAs/MGs is described in the table below:

SERVICES	PLAN	IPA/MG
PRIMARY CARE		X
SPECIALTY CARE		X
IN-PATIENT HOSPITAL (includes in-patient pharmacy, diagnostics and ancillary services)	Shared	Shared
OUT-PATIENT PHARMACY	X	
MENTAL HEALTH	X	
EMERGENCY SERVICES	out of area	in area
LABORATORY SERVICES		X
DIAGNOSTIC SERVICES		X
ALLIED HEALTH SERVICES		X
NURSING HOME	Shared	Shared
HOME HEALTH	Shared	Shared
HOSPICE	Shared	Shared
OTHER		
*Chiropractic**	*N/A*	*N/A*
*Vision**	*X*	
*Mental Health**		*X* *Healthy Families only*

**The Plan contracts with several other entities to provide chiropractic, vision and mental health services to enrollees.*

Delegated Authority to IPA/MG

The Plan has delegated the following responsibilities to the contracting IPA/MGs:

IPA/MG	Utilization Management/ Treatment Authorizations	Credentialing	Quality Assurance	Grievances & Appeals
Asian Community Medical Group	YES	YES	NO	NO
California Pacific Physician Medical Group	YES	YES	NO	NO
Advantage Health Network	YES	YES	NO	NO
San Miguel IPA	YES	YES	NO	NO
Preferred IPA	YES	YES	NO	NO
University Affiliates IPA	YES	YES	NO	NO
Cal Care Medical Group	YES	YES	NO	NO
Crown City Medical Group	YES	YES	NO	NO
Los Angeles Medical Center	YES	YES	NO	NO
Pacifica Alliance Medical Group	YES	YES	NO	NO
Physicians Healthway Medical Group	YES	YES	NO	NO
Allied Physicians of California	YES	YES	NO	NO
Angeles IPA	YES	YES	NO	NO
La Vida Medical Group	YES	YES	NO	NO
Global Care IPA	YES	YES	NO	NO
St. Peter Medical Group	YES	YES	NO	NO
Serra Medical Group	YES	YES	NO	NO
Accountable Health Plan IPA	YES	YES	NO	NO
Southland San Gabriel Medical Group	YES	YES	NO	NO
Healthcare LA IPA	YES	YES	NO	NO
Southern California Medical Group	YES	YES	NO	NO
Bell Vista Medical Group	YES	YES	NO	NO
Mission Community IPA	YES	YES	NO	NO
*Harvard Healthcare Medical Associates	YES	NO	NO	NO

*Harvard HMA is not delegated for credentialing

Plan Oversight Activities

To monitor the delegation of utilization management functions, the Plan requires a monthly report of all utilization management activity from its delegates. The Plan also monitors grievances from both enrollees and providers regarding delays in obtaining authorization for referral services and requires delegates to submit corrective action plans if systematic problems are identified. The Plan meets with each contracting IPA/MG quarterly in a Joint Operations Committee (JOC) meeting to review IPA and Plan issues in utilization management, as well pharmacy utilization, quality management, provider relations, member services, health education, and finance. The Plan also performs a utilization management oversight review of each IPA/MG annually, using the National IPA Coalition (NIPAC) tool.

To monitor the delegation of credentialing functions, the Plan performs a pre-delegation review of policies and procedures, committee minutes and a sample of credentialing and re-credentialing files. Ongoing monitoring is performed through annual audits, which consist of further policy and procedure review, review of committee minutes, file review to determine compliance to Plan standards. In addition, the IPA/MG is required to provide the Plan profiles of all newly approved physicians within thirty (30) days of their approval.

Plan Audit:

The Plan performs scheduled audits of IPAs/MGs for delegated utilization management and credentialing functions. Medical records of participating PCPs are audited at the time of annual facility site reviews and when new physicians join the practice. UM oversight review was performed for all IPA/PMG within the last 12 months.

PLAN OVERSIGHT	AUDIT SCHEDULE
UTILIZATION MANAGEMENT	ANNUAL
QUALITY ASSURANCE	N/A
GRIEVANCES	N/A
CREDENTIALS	ANNUAL
OTHER: Medical Records	ANNUAL

III. SUMMARY OF DEFICIENCIES FOUND BY THE DEPARTMENT'S SURVEY

The Department of Managed Health Care's routine medical survey of the Plan found the following deficiencies, which the Plan is required to correct:

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan does not demonstrate the separation of medical services from fiscal and administrative management sufficient to assure the Department that medical decisions will not be unduly influenced by fiscal and administrative management. [Section 1367(g); Rules 1300.67.3(a)(1) and (3)]

Deficiency 2: The Plan's QA program does not sufficiently demonstrate that follow up is planned and undertaken following implementation of corrective action plans. [Rule 1300.70(a)(1)]

ACCESSIBILITY OF SERVICES

Deficiency 3: The plan does not ensure that the enrollees' residence or workplace be located within thirty (30) minutes travel time or fifteen (15) miles of contracting hospitals and facilities for providing ancillary services. [Rules 1300.51H(ii) and (iv)]

Deficiency 4: The Plan does not have an adequate documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments. [Rule 1300.67.2(f)]

GRIEVANCE SYSTEM

Deficiency 5: The Plan's grievance system does not consistently provide for the acknowledgment of the receipt of grievances/appeals and notice to complainant of who may be contacted with respect to the complaint within five (5) days. [Rule 1300.68(b)(7)]

Deficiency 6: The Plan does not consistently provide written responses to enrollees with clear and concise explanations of the reasons for the Plan's denial or modification of health care services. [Section 1368(a)(4)]

Deficiency 7: The Plan does not consistently notify eligible enrollees in writing of the opportunity to request external independent review within five (5) business days of the decision to deny, modify or delay health care services. [Section 1370.4(c)(1)]

Deficiency 8: The Plan does not prominently display information on its enrollee grievance/appeal forms concerning the right of the enrollee to request an Independent Medical Review. [Section 1374.30(i)]

UTILIZATION MANAGEMENT

Deficiency 9: The Plan does not consistently communicate decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees within twenty-four (24) hours of the decision. [Sections 1367.01(h)(3) and (4)]

Deficiency 10: The Plan does not consistently notify the provider and enrollee of the anticipated date on which a decision may be rendered in cases where the Plan cannot make a decision within the time frames it specified or where the Plan is not in receipt of all the reasonably necessary information. [Section 1367.01(h)(5)]

Deficiency 11: The Plan does not adequately demonstrate that utilization review determinations are consistent with criteria or guidelines that are supported by sound clinical principles and processes. [Section 1363.5(b)(2); Section 1367.01(b)]

Deficiency 12: The Plan and its delegates do not demonstrate that its written policies and procedures establish the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, respectively or concurrently with, the provision of health care services to plan enrollees. [Sections 1367.01(a) and (b)]

Deficiency 13: The Plan does not disclose to the provider and the enrollee the criteria used as the basis of a decision to modify, delay, or deny services nor does it provide a direct number or an extension to allow the physician to easily contact the health care professional responsible for the denial, delay, or modification. [Section 1363.5(b)(4); Section 1367.01(h)(4)]

Deficiency 14: The Plan's written responses to the providers and enrollees regarding decisions to deny, delay, or modify health care services do not include a clear and concise explanation of the reasons for the plan's decisions. The response does not also include a clear and easy to follow instruction as to how the enrollee may file a grievance with the Plan pursuant to Section 1368. [Section 1367.01(h)(4)]

IV. SUMMARY OF PLAN'S EFFORTS TO CORRECT DEFICIENCIES

Upon review of the Plan's response to the Preliminary Report, the Department found that the following deficiencies have been corrected:

- Grievance System: **Deficiency 5**
- Utilization Management: **Deficiency 9, 12**

For all other Deficiencies cited, the Department found that although the Plan had initiated corrective actions, full implementation of those actions, and assessment of the effectiveness, will require more then forty-five (45) days. The deficiencies that remain uncorrected are as follows:

- Quality Assurance: **Deficiency 1, 2**
- Accessibility of Services: **Deficiency 3, 4**
- Grievance System: **Deficiency 6, 7, 8**
- Utilization Management: **Deficiency 10, 11, 13, 14**

V. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

QUALITY ASSURANCE PROGRAM

Deficiency 1: **The Plan does not demonstrate the separation of medical services from fiscal and administrative management sufficient to assure the Department that medical decisions will not be unduly influenced by fiscal and administrative management.** [Section 1367(g); Rules 1300.67.3(a)(1) and (3)]

Citation: Section 1367(g)
Each health care service plan and, if applicable, each specialized health care service plan shall meet the following requirements:
(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The Plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

Citation: Rule 1300.67.3(a)(1)
The organization of each plan shall provide the capacity to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees contracted. Such organization shall include:
(1) separation of medical services from fiscal and administrative management sufficient to assure the Department that medical decisions will not be unduly influenced by fiscal and administrative management.

Citation: Rule 1300.67.3(a)(3)
(3) written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

Discussion: The medical officer making a determination to uphold an appeal is the same one who makes the initial denial decision. During the review of appeal files, three (3) appeals cases were reviewed by the same physician, (the Chief Medical Officer), who had made the initial denial decision. The Plan acknowledges that this is a significant conflict of interest and inappropriate.

In the QM program description under the Chief Medical Officer (CMO) responsibilities, it is stated that the CMO ensures that medical necessity decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management. However, there is no mention as to how the requirement is enforced or supervised throughout the entire organization. On page 9, paragraph 3.6 of the "Capitated MG/IPA Agreement", it states that the medical group will not penalize participating physicians for authorizing appropriate medical care and referrals. Nothing in the document addresses or prevents the issue of possibly rewarding providers for withholding medical care.

The Plan requires medical directors of delegated groups making medical necessity decisions sign a document entitled "Provider Panel Member Confidentiality Statement". In the third paragraph of this document, the issue of financial rewards possibly influencing medical decisions is addressed. However, the Plan's own medical officers involved in medical decisions have not signed this type of document.

The Plan does not have any written policy or procedure in place to demonstrate an adequate separation of medical decisions from fiscal matters. There is no signed document reflecting that medical decision-making is not hindered by financial or administrative considerations. The Plan does not have a policy that states that anyone that is involved in the UM process is not to be financially rewarded for denying care.

Corrective Action Plan 1: The Plan shall submit a corrective action plan that demonstrates the separation of medical services from fiscal and administrative management sufficient to assure the Department that medical decisions will not be unduly influenced by fiscal and administrative management. The Plan shall submit evidence and supporting documentation of the mechanisms it uses to demonstrate adherence to the policy.

Plan's Compliance Effort: The Plan stated that it has modified two policies and procedures: **(1)** *Provider/Member Clinical Grievance Process* policy and procedure (*UM Policy #2.0.24*) to allow qualified physicians in the relevant field, other than the Chief Medical Officer (CMO), to review appeals when the CMO has made the initial decision and, **(2)** corporate level *Conflicts of Interest Policy (Administration Policy #0.2.1)* to clearly set out the policy that medical decisions will not be unduly influenced by fiscal and administrative management. The Plan submitted copies of the policies and procedures with their response to the Preliminary Report.

The Plan stated that it has modified the statement all physicians and other health professionals, including the CMO and his associates, have to sign prior to participating in committee work involving health care decisions to read:

"I also declare that I have no financial interest in Care 1st Health Plan, that I will disclose to the relevant committee any conflicts of interest in a matter the committee is in the process of reviewing and will not take part in the deliberation of that matter by the committee, and I will immediately bring to the attention of the CMO if any shareholder, director or executive of the Plan has exerted or attempted to exert undue influence on the person to induce the person to make a decision relating to the quality of, access to, or utilization of health care services. I am aware that any medical decisions made in this committee are separated from any financial decision-making. I have read, understand and agree to abide by the above."

The Plan stated that its CMO and other health professionals of the plan are now required to sign a statement that their medical decisions will not be influenced by plan fiscal and administrative management. The Plan submitted copies of the policies and procedures along with the Conflict of Interest Statement signed by the CMO.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated the separation of medical services from fiscal and administrative management sufficient to assure the Department that medical decisions will not be unduly influenced by fiscal and administrative management.*

The Department found that while the Plan's revised policy on Conflicts of Interest (Policy #0.2.1) partly demonstrates the Plan's intent to separate medical services from fiscal and administrative management, the Provider/Member Clinical Appeals Process (UM Policy #2.0.24) failed to demonstrate that appealed denials are reviewed consistently by a qualified physician other than the physician who issued the initial denial. Nothing in the policy states that the physician who issued the initial denial shall not participate in the review of the appeals. UM Policy #2.0.24 does not appear to have been revised, as stated by the Plan in its response. The revision date of January 2001 in the policy occurred prior to the medical survey in August 2001.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review. The Plan shall produce documented evidence during the Follow-up Review that a qualified physician reviewer other than the physician who issued the initial denial is consistently reviewing appeals.

Deficiency 2: **The Plan's QA program does not sufficiently demonstrate that follow up is planned and undertaken following implementation of corrective action plans.** [Rule 1300.70(a)(1)]

Citation: Rule 1300.70(a)(1)
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that, problems are identified, and that follow up is planned where indicated.

Discussion: The Plan tracks and trends sentinel events, potential quality of care issues, grievances, appeals and authorizations and performs a full range of quality improvement activities. These activities set forth goals, perform interventions, measure outcomes, and report the results. However, the plan fails to re-measure the results of the study after the corrective action plan is implemented. An example of this is the Mammogram Outreach Program. Defined patients not having a mammogram within accepted timeframe are identified by the study and this information is sent to the patient's primary care physician by registered mail. Physicians are thereby notified in writing as to the study results. The problem with the study,

however, is the failure to re-measure the results of the study after the corrective action plan was implemented. The purpose of continuous quality improvement (CQI) is to identify problems, implement interventions, measure results, implement corrective actions and then re-measure the results, thus completing the circle of CQI. The Plan has completed all but the last step in the CQI process.

Corrective Action Plan 2: The Plan shall submit a corrective action plan that sufficiently demonstrates that it conducts follow-up after implementation of corrective action plans.

Plan Compliance Effort: The Plan stated that in the 2002 Work Plan it would have a planned follow-up evaluation of the Mammogram Outreach Program. Each year, the Plan stated, the Quality Management Department conducts annual evaluations of the Member/Provider Satisfaction Surveys, Access Studies, Grievances, and Potential Quality Issues. These evaluations compare results from the previous years and evaluate corrective actions that were taken. The Plan intends to present the 2001 Annual Evaluation and 2002 Work Plan at the next Medical Services Committee Meeting for approval on January 23, 2002.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan's QA program has not sufficiently demonstrated that follow-up is planned and undertaken following implementation of corrective action plans.*

The Plan has not submitted any evidence to support their stated response. The Plan stated that its 2002 Workplan would contain a follow up evaluation of the Mammogram Outreach Program. However, the Plan did not provide any time frame as to when the re-measurement might take place and how it plans to re-measure the program. In addition, the Plan must ensure that the re-measurement process occurs with ***all other*** *applicable Quality Improvement (QI) projects as well.*

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

ACCESSIBILITY OF SERVICES

Deficiency 3: **The plan does not ensure that the enrollees' residence or workplace be located within thirty (30) minutes travel time or fifteen (15) miles of contracting hospitals and facilities for providing ancillary services.** [Rules 1300.51H(ii) and (iv)]

Citation: Rules 1300.51H
(ii)
Hospitals. In the case of a full service plan, all enrollees have a residence or workplace within thirty (30) minutes or fifteen (15) miles of a contracting or plan operated hospital which, has a capacity to serve the entire dependent population.

(iv)
Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

Discussion: The Plan has a draft policy on availability of hospitals, which states that members must be assigned within 30 minutes or 15 miles from their contracting hospital and that the Plan provides transportation for all members without transportation. The Plan also has a draft policy on the availability of ancillary providers which states that "the ancillary services must be within a reasonable distance from the PCP." However, the "reasonable distance" is not defined. The draft policy further states that the Plan's added transportation service will assure that the member will be within reasonable distance for ancillary services. These draft policies have not been formally adopted, approved by the appropriate body, and implemented by the Plan.

Corrective Action Plan 3: The Plan shall submit a corrective action plan that demonstrates formal adoption and implementation of Plan's draft access policy. Further, the corrective action plan shall demonstrate that the Plan's policies for the provision of ancillary services clearly define "reasonable distance" and that such definition reflects the regulatory requirements.

Plan's Compliance Efforts: The Plan submitted the policy *Availability of Practitioners (Policy #1.1.29)*. The Plan stated that it has revised the policy and procedure to state the standard 30 minutes or 15 miles from the members' PCP's office. The Plan stated that it continues to provide transportation for members without transportation. The Plan intends to take the revised policy before the appropriate committee on January 23, 2002 for formal approval and adoption.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Plan has adequately defined the phrase "reasonable distance" in the revised policy and procedure. However, the Department found that the Plan has not adequately demonstrated that enrollees' residence or workplace be located within thirty (30) minutes travel time or fifteen (15) miles of contracting hospitals and facilities for providing ancillary services. While the Plan stated in writing that it would formally adopt and implement the draft Policy #1.1.29 by January 23, 2002, it does not appear that the policy has actually been implemented, formally or informally.*

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 4: **The Plan does not have an adequate documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments.** [Rule 1300.67.2(f)]

Citation: Rule 1300.67.2(f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

Discussion: The Plan generates a number of reports and conducts annual member satisfaction surveys to assess overall access and availability of primary care physicians, specialty care physicians, and hospital providers. However, the Plan lacked evidence that critical data analysis is performed to ensure that access problems can be identified and interventions can be implemented in a timely manner.

In the 1999 member satisfaction survey, "Number of PCPs to Choose From" was rated "very good" by forty-four percent (44%) of the respondents. "Location of Hospital You Can Use" was rated "good" by forty-six percent (46%). In the 2000 member satisfaction survey, eighty-two percent (82%) rated "Number of PCPs to Choose From" and "Location of Hospital You Can Use" as good and very good.

The grievance aggregate report in 2000 showed seven complaints related to PCP access and two complaints related to specialty access. This year, as of July 2001, two complaints have been received regarding PCP access and four complaints regarding specialist access.

In the 1999 report "PCP Transfer", an average of 217 enrollees per month requested transfer due to "proximity to area". In 2000, an average of 106 enrollees per month requested transfer for the same reason. The last five months of 2000 showed that the average number of enrollees requesting PCP transfer increased significantly from 80 enrollees per month to 140 per month. This trend continues and has worsened in 2001. As of July 1, 2001, there is an average of 185 enrollees per month requesting PCP transfer due to "proximity to area".

Based on the report generated and utilized by the Plan (*QueryZipDistanceM5 #1*), PCP panel sizes range from 0 to 1,494 enrollees, with most PCPs having a few to several hundred members. This panel size includes all enrollees within the Plan network. The Plan staff indicated that the Plan's database does not permit assignment of enrollees to any PCP with a panel size greater than 2,000. The Plan has tracked reasons for PCP transfers for at least the last three years. PCP changes made because of a closed panel averaged five per month in 2000 and eight for the first seven months of 2001.

In its pre-survey materials, the Plan identified Optometry, OB/GYN, Podiatry and Dermatology as its high volume specialties based on monthly authorization reports that track the referrals to different specialists. In 2001, one of the Plan's reports (*QueryZipDistanceM5#2*) shows potential limited access to dermatologists. However, two of the five practitioners interviewed

indicated that referral to other specialties such as endocrinology and orthopedics is difficult. The practitioners stated that a referral to an orthopedist could take up to two months. The Plan did not identify the specialist access issue for endocrinology and orthopedics.

In 2000, the Plan contracted with an external vendor to conduct an after-hour survey. The vendor contacted a random sample of 595 adult and pediatric provider offices to assess if after-hour access was available to members. An acceptable response included a call answered by an answering service or a message clearly instructing the member how to reach a practitioner or access emergency services. The Plan reported eighty-two percent (82%) of providers met the standard. Of the calls that reached a recording, thirty-five percent (35%) did not have instructions about calling 911 for emergencies.

The Plan staff indicated that they have not completed the analysis phase. The Plan staff stated that they are currently conducting the analysis of PCPs, high volume specialists and hospital reports. To date, the Plan has not formally identified opportunities for improvement in the availability of PCPs and specialists.

Corrective Action Plan 4:

1) The Plan shall submit a corrective action plan that demonstrates that the Plan have an adequate documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting times and appointments**.**

2) The Plan shall submit evidence and supporting documentation that it conducts thorough analysis of access/availability data for primary care physicians, specialty care physicians, hospital, and ancillary providers.

3) The Plan shall submit evidence and supporting documentation that it identifies and addresses problems that develop.

Plan's Compliance Effort: The Plan stated that it would change the annual access audit to include waiting times. The question in the Member Satisfaction Survey form on waiting time will be modified to read: *"How long did you have to wait at the doctors office or clinic before being seen by the doctor?"* The Plan also stated the Quality Management (QM) Department reviews and tracks grievance issues concerning prolonged waiting times and appointments. The QM Department will conduct a thorough analysis that includes all of the above sources of information. Corrective actions will be developed and follow-up evaluations will be conducted to measure improvements. The 2001 QM Work Plan evaluation and 2002 QM Work Plan will be presented at the next Medical Services Committee meeting on January 23, 2002.

The Plan submitted a copy of the *Access to Care Standards and Monitoring Process (Policy No: 1.1.8)*. These policies and procedures are said to have been revised to include access and availability standards for primary care providers, specialty care providers, hospital, and ancillary care services. Appendix D contains a listing of the Plan's access to care standards. The Plan stated it would present the revised policy and procedures at the Medical Services Committee meeting for approval on January 23, 2002.

In addition, the Plan stated that it has conducted some analysis of the accessibility of practitioners in 2001 and identified Endocrinology and Orthopedics as specialties that are needed in specific geographic regions of the Plan's network. The Plan submitted a four-page computer generated table entitled "Consolidated Ortho Endo" which appears to be a log of orthopedists and endocrinologists in various areas of Los Angeles. The Plan stated that its Provider Relations/Contracting Department is working on the accessibility issues of these specialties in certain regions and is in the process of contracting additional specialists in these regions to meet the needs of their network.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not demonstrated a detailed documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that could develop.*

The Plan's revised policy and procedures on accessibility include what officers and committees in the organization shall be responsible for analyzing the data gathered through various surveys, member complaints and grievances, disenrollments, etc., and how interventions are to be implemented and re-evaluated. The Plan stated that it has identified, through some analysis in year 2001, that it needs orthopedists and endocrinologists in certain areas. The Plan submitted evidence (i.e. consolidated ortho endo table) that its Contracting Department has started to call orthopedists and endocrinologists in certain regions. However, the Plan presented no evidence of any formal critical analysis of the data it gathers, including the analysis that led ***(1)*** *the identification of the two problem specialty areas,* ***(2)*** *what opportunities for improvements have been identified, and* ***(3)*** *how it plans to correct identified deficiencies. The Plan did not present any evidence of any discussions on how it plans to correct their practitioner accessibility, availability, and other related issues. This is of particular concern to the Department given that there appears to be a worsening trend based on data from the member satisfaction surveys with regard to enrollees requesting PCP transfers due to proximity to area.*

Further Remedial Action: The Plan shall revise its corrective action plan (CAP) to demonstrate that it sufficiently analyzes the data to identify barriers to access and availability and initiate corrective actions in a timely manner to address these barriers. The Plan shall demonstrate a process used to monitor improvements or on-going problems. The Plan shall submit its revised CAP, as stated above, within thirty (30) days of the date that the Plan receives the Final Report.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

GRIEVANCE SYSTEM

Deficiency 5: **The Plan's grievance system does not consistently provide for the acknowledgment of the receipt of grievances/appeals and notice to complainant of who may be contacted with respect to the complaint within five (5) days.** [Rule 1300.68(b)(7)]

Citation: Rule 1300.68(b)(7)
A grievance system shall provide for the acknowledgment of the receipt of a complaint and notice to the complainant of who may be contacted with respect to the complaint within five (5) days.

Discussion: Six of twenty (or 30%) grievance files reviewed did not contain evidence of written acknowledgment to the enrollee and notice to the complainant of who may be contacted within five (5) days of receipt by the Plan.

Corrective Action Plan 5: The Plan shall submit a corrective action plan that provides for the consistent acknowledgment of the receipt of grievances/appeals and notice to complainant of who may be contacted within five (5) days.

Plan's Compliance Effort: The Plan stated that it has hired a new Director of Member Services in mid October 2001. Since then, oversight of the grievance process has been in place to ensure that acknowledgment letters were sent within the required five days. The Plan stated that during the months of October and November 49 grievances were received, of those 49, all have been sent acknowledgment letters within the required five (5) days.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Corrected***

The Plan has corrected the deficiency as requested.

Compliance Effort Discussion: *The Department found that the Plan has adequately demonstrated consistent acknowledgment of the receipt of grievances/appeals and notice to complainant of who may be contacted with respect to the complaint within five (5) days.*

The Plan submitted a log of grievances received in October 2001 with their response to the Preliminary Report. All 30 grievances were acknowledged within 5 days.

Deficiency 6: **The Plan does not consistently provide written responses to enrollees with clear and concise explanations of the reasons for the Plan's denial or modification of health care services.** [Section 1368(a)(4)]

Citation: Section 1368(a)(4)
Every plan shall do all of the following:
(4) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial or modification of health care services, the plan's response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity.

Discussion: Four of twenty (or 20%) appeal files reviewed contained written responses to the enrollee with inadequate explanations of the reason for the Plan's denial or modification of health care services. The plan did not cite specific reasons or clinical criteria or guidelines to explain the decision to uphold an appeal. The Plan used generic statements such as "not medically necessary" or "clinical condition did not support the level of care."

Corrective Action Plan 6: The Plan shall submit a corrective action plan that demonstrates consistent provision of written responses to enrollees with clear and concise explanations of the reasons for the Plan's denial or modification of health care services.

Plan's Compliance Effort: The Plan stated that it has already implemented the changes in the denial/modification letters to provide clear and concise explanations for the determinations. The Plan attached copies of the clinical criteria used for the determinations to the denial/modification letters sent to enrollees and providers.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated consistent provision of written responses to enrollees with clear and concise explanations of the reasons for the Plan's denial or modification of health care services.*

The Plan submitted copies of three actual Notification of Denial, Deferral, or Modification of Requests for Authorization sent to enrollees and providers. The requested services and reasons for denial and modification are as follows:

Requested Service	Action Taken	Reason as stated in the notification letter
Gastroenterology consult	Denied	"PCP to give trial of conservative treatment. Recommend Chest X-ray" (a copy of PCP Responsibilities was attached to the letter)
CTScan of the Head	Modified	"Request for CTScan of the head has been modified to neurology evaluation to fully assess patient needs. Member has been authorized to see Dr... " (a copy of criteria for CTScan of the head was attached to the letter)
Total Hysterectomy	Modified	"There is no medical necessity for out of network provider. Member must see contracted provider in network. Pls. Refer member to Dr._____

The requirement [Section 1368(a)(4)] states the Plan's response shall describe the criteria used and the clinical reasons for its decisions.

While the Plan attaches a copy of the criteria used to the notification letters to enrollees, the Plan does not make reference to the criteria used nor does it describe the clinical reasons for its decisions. The Plan simply attaches a copy of the applicable criteria.

The specific reason stated in the table above for modifying CTScan of the head was unclear and confusing. It is not clear if the CTScan is being deferred until the result of a neurology consult is available or if the enrollee is offered an alternative service or treatment.

In the case of the example of the requested Total Hysterectomy, it is not clear what is being denied or modified. Questions come to mind such as, "is the total hysterectomy approved as long as the patient goes to a network provider"? or " is it deferred or pended until patient sees a network provider"? The reason for denial did not address the requested service, which is the total hysterectomy.

Copies of actual upheld denial letters were submitted in the Plan's response to Deficiency 7. The reasons for upheld denials as stated by the Plan in the notification letters are as follows: ***(1)****"based on the information received, the decision is to uphold the denial for untimely notification",* ***(2)*** *"Based on the additional information received the decision is to modify the denial. Authorized for 5/31/01 after 5/31/01, patient can be managed as out-patient". These reasons are inadequate and do not meet the applicable requirement.*

The Plan submitted a copy of the monthly fax log of denied and modified services. A number of the reasons for modified services remains vague, e.g., "Mammogram approved" and "Pelvic ultrasound not indicated based on info provided". In the case of a request for echo exam of a kidney transplant, the reason reads: "approved for gastroenterology consult". These reasons are vague and do not meet the applicable requirement.

An example of a concise and clear denial reason is as follows:

> "in the absence of trauma or suspected bleeding, the clinical condition presented does not meet the guidelines for CTScan of the head. A copy of the M & R guidelines used is attached. Recommend neurology consult with …"

The Plan needs to define and identify which situations fall under the categories of denial, modification, deferral and pended. The Plan needs to demonstrate that these definitions are applied consistently.

Further Remedial Action: The Plan must revise its corrective action plan to provide for clear definitions of denied, modified, deferred and pended requests. The Plan must show evidence that it consistently provides a clear and concise reason for denying, modifying, pending and deferring services.

The Plan shall submit its revised CAP, as stated above, within thirty (30) days of the date that the Plan receives the Final Report.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 7: **The Plan does not consistently notify eligible enrollees in writing of the opportunity to request external independent review within five (5) business days of the decision to deny, modify or delay health care services.** [Section 1370.4(c)(1)]

Citation: Section 1370.4(c)(1)
The Plan shall notify eligible enrollees in writing of the opportunity to request external independent review within five (5) business days of the decision to deny coverage.

Discussion: One of three (or 33%) upheld appeal files reviewed did not meet the requirement to offer Independent Medical Review (IMR) for upheld medical necessity denials within five (5) days of the decision. The file in question was a partial overturn (modification) of a previous denial for medical necessity and IMR was not offered to the enrollee.

Corrective Action 7: The Plan shall submit a corrective action plan that demonstrates that the Plan consistently notifies eligible enrollees in writing of the opportunity to request external IMR within five (5) business days of the decision to deny, modify or delay health care services.

Plan's Compliance Effort: The Plan stated that its Utilization Management Department has added the Independent Medical Review Process to the current denial/modification letters to enrollees. The Plan also stated that it added the Independent Medical Review Process to the appeals resolution letters to enrollees.

Department's Finding Concerning Plan's Compliance Effort:

Status: *Not Corrected*

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated that it consistently notifies eligible enrollees in writing of the opportunity to request external independent review within five (5) business days of the decision to deny, modify, or delay health care services.*

The Plan presented actual copies of the six-page initial notification letters for denial/modification of services. The letters include, as part of the body of the letters, the information regarding the independent medical review process. In addition, the Plan developed a separate sheet, "Independent Medical Review Application", which is to be attached to the two-page letter "Notification on Appeal Determination". The letter for Notification on Appeal Determination does not mention the IMR process nor does it mention the attachment to appropriately direct the enrollee to the actual IMR Application. The Department's concern with the Plan's procedure is that the separate sheet of IMR Application may not be attached consistently to the letters and the recipients (enrollee) will not know that it is missing. It will be difficult to determine whether or not the enrollee was

sent the letter with the IMR Application. It would only be upon review of actual appeal case files that the presence or absence of the IMR Application would become apparent. The Plan presented no documented mechanism to ensure that the staff adheres to the procedure.

Further Remedial Action: The Plan must include the information regarding the right to an IMR in all of its notification for denial letters. The Plan shall submit evidence within thirty (30) days of the date that the Plan receives the Final Report including sample of actual revised denial letters and a detailed documented procedure to ensure staff adherence.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 8: **The Plan does not prominently display information on its enrollee grievance/appeal forms concerning the right of the enrollee to request an Independent Medical Review.** [Section 1374.30(i)]

Citation: Section 1374.30(i)
No later than January 1, 2001, every health care service plan shall prominently display in every plan handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368 and on all written responses to grievances, information concerning the right of enrollees to request an Independent Medical Review in cases where the enrollee believes that health care services have been improperly denied, modified or delayed by the plan, or by one of its contracted providers.

Discussion: In general, the availability of IMR appeals is prominently included in the enrollee handbook and denial notices. However, the Department was unable to find any reference to IMR on the enrollee grievance/appeal forms.

Corrective Action 8: The Plan shall submit a corrective action plan that provides for the prominent display of information on enrollee/grievance forms concerning the right of the enrollee to request IMR cases where the enrollee believes that health care services have been improperly denied, modified or delayed by the Plan or by one of its contracted providers. The Plan shall submit evidence and supporting documentation to demonstrate adherence to this requirement.

Plan's Compliance Effort: The Plan stated that it has added a one-page insert sheet containing the required IMR language. In addition, the Plan states its grievance policy has been modified to include the process of inserting the IMR form with all Member grievance forms.

Department's Finding Concerning Plan's Compliance Effort:

Status: *Not Corrected*

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated that it prominently displays information on its enrollee grievance/appeal forms concerning the right of the enrollee to request an Independent Medical Review.*

While the plan submitted a copy of the revised Grievance policy and procedure "Administrative Grievance Management" (Policy No: 3.2.3), along with the copy of the two-page insert containing the required IMR language, the Department found no evidence that the enrollee grievance/appeal form has been revised to include IMR notice or to make reference to the IMR insert.

Further Remedial Action: The Department requires that the Plan submit a revised enrollee grievance/appeal form, which includes IMR notice or clearly references the IMR insert. The Plan shall submit the document within thirty (30) days of the date that the Plan receives the Final Report

UTILIZATION MANAGEMENT

Deficiency 9: **The Plan does not consistently communicate decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees within twenty-four (24) hours of the decision.** [Sections 1367.01(h)(3) and (4)]

Citation: Section 1367.01(h)(3)
Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the provider within twenty-four (24) hours of the decision.

Citation: Section 1367.01(h)(4)
Responses regarding decisions to deny, delay or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile.

Discussion: The Plan's Authorization Referral Turn Around Times policy requires that the requesting provider be notified via facsimile within 24 hours of the decision. The Plan has an automatic fax function that transmits the determination notices at the end of each day. In six of fourteen (or 44%) denial files reviewed, the Plan did not notify the requesting provider within 24 hours of making the determination.

Corrective Action Plan 9:

1) The Plan shall submit a corrective action plan that provides for the consistent communication of decisions to approve, modify or deny requests, by providers for authorization prior to, concurrent with, the provision of health care services to enrollees within 24 hours of the decision.

2) The Plan shall submit evidence and supporting documentation of a monitoring system to assure that copies of the written determination notices to approve, modify or deny requests are sent by facsimile or by telephone within 24 hours of the determination.

Plan's Compliance Effort: The Plan stated that it has changed the process of sending denial/modification notices to the provider and enrollees for both approved and denied services. A fax log is generated monthly by the UM Data Analyst to monitor the referrals that were sent within 24 hours of the determination.

For denial/modification notices, the Plan stated that it has implemented a separate denial/modification database to track all the denial/modifications notices. After the Chief Medical Officer approves the denial notice, it is reported to be faxed to the requesting provider within 24 hours of making the determination. The original copy of the denial/ modification notice is sent to the enrollee the next business day. A denial log is maintained monthly to monitor the turn around time.

Department's Finding Concerning Plan's Compliance Effort:

Status: *Corrected*

The Plan has corrected the deficiency as requested.

Compliance Effort Discussion: *The Department found that the Plan has adequately demonstrated that it communicates decisions to approve, modify, or deny requests by providers for authorization of services prior to or concurrent with the provision of health care services to enrollees within twenty-four (24) hours of the decision.*

The Plan submitted computer generated denial and approved logs for the months of November and December 2001 respectively. There is adequate evidence in the logs provided that the Plan has consistently sent communication to the providers within 24 hours of making a determination.

Deficiency 10: **The Plan does not consistently notify the provider and enrollee of the anticipated date on which a decision may be rendered in cases where the Plan cannot make a decision within the time frames it specified or where the Plan is not in receipt of all the reasonably necessary information.** [Section 1367.01(h)(5)]

Citation: Section 1367.01(h)(5)
If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the time frames specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary…the plan shall, immediately upon the expiration of the time frame specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the time frame whichever comes first, notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify or deny the request for authorization with the time frames specified in paragraph (1) or (2), whichever applies.

Discussion: In three of 14 (or 20%) denial files reviewed, the decision was delayed because additional information was required. In these three cases, no notice was sent to the provider and/or the enrollee that the decision would be delayed. Interviews conducted with staff indicate that the notification of delay is not a standard operating procedure for the prior authorization, concurrent, or retrospective review processes.

Corrective Action Plan 10: The Plan shall submit a corrective action plan that provides for consistent notification of providers and enrollees of the anticipated date on which a decision may be rendered in cases where the Plan cannot make a decision within the time frames it specified or where the Plan is not in receipt of all the reasonably necessary information.

Plan Compliance Effort: The Plan stated that it has a written policy for pending referrals. In its policy, the Plan stated that it allows five (5) working days to pend a referral. If a determination cannot be made by the 5th working day or where the Plan is not in receipt of all the reasonably necessary information, a notification is sent to the provider and the enrollee to indicate the decision would be delayed and the anticipated date on which a decision may be rendered.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated that it consistently notifies the provider and enrollee of the anticipated date on which a decision may be rendered in cases where the Plan cannot make a decision within the timeframes it specified or where the Plan is not in receipt of all the reasonably necessary information.*

The Plan submitted a copy of the UM policy and procedure titled "Pended Authorization Requests" (Policy No: 2.0.45). The policy states that "immediately upon expiration of the timeframe or as soon as the Plan is aware that it will not make the timeframe (5 days maximum), a letter will be sent to the member apprising them of the delay. The components of the letter shall include the reason for the delay such as ***(1)*** *"Specific information requested or not received," and* ***(2)*** *"The plan's anticipated timeframe to get the information and make a determination". It is also stated in the policy that the "MHC computer system" houses the data on pended authorizations and is able to generate aging reports of pended authorizations to assist in complying with turn around timeframes.*

The Plan has not submitted any evidence that enrollees and providers are indeed notified appropriately and in a timely manner. The Plan did not submit samples of actual letters sent to enrollees. Since it appeared at the time of the on site medical survey that notification of enrollees with pended requests was not a standard operating procedure, the Plan must demonstrate to the Department that the Plan's policy and procedures have been implemented and are actually followed.

Further Remedial Action 10: The Plan shall submit a revised corrective action plan that provides for documented evidence of consistent notification of providers and enrollees of the anticipated date on which a decision may be rendered in cases where the Plan cannot make a decision within the timeframes it specified or where the Plan is not in receipt of all the reasonably necessary information.

The Plan shall submit evidence within thirty (30) days of the date that the Plan receives the Final Report including a sample of actual letters sent to enrollees that would demonstrate that the Plan's policy and procedures are being followed.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 11: **The Plan does not adequately demonstrate that utilization review determinations are consistent with criteria or guidelines that are supported by sound clinical principles and processes.** [Section 1363.5 (b)(2); Section 1367.01(b)]

Citation: Section 1363.5(b)(2)
The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall…
(2) Be consistent with sound clinical principles and processes.

Citation: Section 1367.01(b)
These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

Discussion: In the Plan's 2001 UM Program, page 15, it clearly states the use of nationally recognized UM criteria, such as Milliman & Robertson and several others. However, the Plan does not have a clear description of what and which criteria it uses for various types of utilization management functions, such as specialty referral, admission review, and concurrent review to demonstrate that it uses criteria that are consistent with sound clinical principles and processes, as required by Sections 1363.5(b)(2) and 1367.01(b). There is no clear description of how non-physicians and physician staff members apply the criteria in making medical necessity determinations. For both the in-patient and referral reviews, there is no evidence in the UM case files inspected that the Plan's reviewers (nurse and physician) used the designated criteria in making medical necessity and benefit determinations.

An interview with the UM staff confirmed that reviewers do not cite specific Milliman & Robertson criteria in their concurrent review files when approving or recommending to Medical Director that services be denied.

Corrective Action Plan 11: The Plan shall submit a corrective action plan that will demonstrate that utilization review determinations are consistent with criteria or guidelines that are supported by sound clinical principles and processes. The Plan shall submit and provide supporting documentation that its UM policy and procedures will clearly state which criteria are used for various utilization management functions, how the utilization management staff apply the criteria, and how the utilization management staff document the application of criteria in the UM case files.

Plan's Compliance Effort: The Plan stated that it has revised the following:

(1) UM policy and procedure to specify what clinical criteria are being used for various types of utilization management functions, **(2)** how the utilization management staff apply the

criteria, and **(3)** how the utilization management staff document the application of criteria in the UM reviews.

In addition, the Plan shall require UM clinical staff and physician to document the criteria used for making medical necessity determinations on the referral work sheets beginning December 2001. The Plan will conduct inter-rater reliability audit annually among the clinical staff to monitor consistency of criteria used in 2002.

The Plan also stated that it is currently looking into a software program that contains sound clinical criteria that can assist the clinical staff and physician in making medical necessity determination consistently by the end of 2002.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated that utilization review determinations are consistent with criteria or guidelines that are supported by sound clinical principles and processes.*

The plan submitted a copy of the 2002 UM Program as supporting documentation to its response. The UM Program enumerated the various clinical criteria used for prospective, concurrent and retrospective reviews and provides for documentation of the criteria used in the "UM referral notes" by the clinical reviewers when making recommendations and determinations.

However, the Plan has not submitted any evidence that the procedure has been implemented and that it is consistently being carried out by the staff, e.g., copies of UM referral notes. The sample denial and modification letters do not specifically cite nor make reference to the criteria used but rather, simply attach a page or two of the criteria. In addition, the Plan has not produced any evidence, nor does it specify when and how it plans to conduct inter-rater reliability audits to ensure consistency in the process and criteria used. It simply stated in the UM Program that it will periodically conduct such audits.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 12: **The Plan and its delegates do not demonstrate that its written policies and procedures establish the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, respectively or concurrently with, the provision of health care services to plan enrollees.** [Sections 1367.01(a) and (b)]

Citation: Section 1367.01 (a)
A health care service plan and any entity with which it contracts for services which include utilization review functions, that plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, respectively or concurrently with, the provision of health care services to enrollees, or that delegated these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

Citation: Section 1367.01(b)
A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees.

Discussion: While the Plan's UM Program describes the scope and the processes for doing utilization review, the Plan's written policies and procedures do not describe what UM functions are delegated to IPAs and medical groups. An estimated seventy-five to eighty percent (75-80%) of the Plan's enrollment is assigned to contracted IPAs and medical groups that are delegated with utilization management functions.

Corrective Action 12: The Plan shall submit a corrective action plan that demonstrates and establishes the process by which the Plan and its delegates prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. The Plan shall submit evidence and supporting documentation that includes the specific functions delegated to the IPAs and MGs and the methods by which the Plan oversees that delegation.

Plan Response and Compliance Efforts: The Plan stated that it has revised the Delegated Utilization Management Policy to include specific functions that are delegated to the IPA's and MGs and methods by which the Plan oversees the delegated functions.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Corrected***

The Plan has corrected the deficiency as requested.

Compliance Effort Discussion: *The Department found that the Plan has adequately demonstrated that its written policies and procedures establish the process by which the plan and its delegates prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity, requests by providers prior to, respectively or concurrently with, the provision of health care services to Plan enrollees.*

The Plan submitted a copy of the revised policy and procedure for QM/UM Delegation and Monitoring titled "Utilization Management Delegation and Monitoring (Policy No: 1.0.3). The revised P & P does describe the process by which delegates carry out specific UM functions, e.g., prospective, concurrent and retrospective review.

Deficiency 13: **The Plan does not disclose to the provider and the enrollee the criteria used as the basis of a decision to modify, delay, or deny services nor does it provide a direct number or an extension to allow the physician to easily contact the health care professional responsible for the denial, delay, or modification.** [Section 1363.5(b)(4); Section 1367.01(h)(4)]

Citation Section 1363.5(b)(4)
If used as the basis of a decision to modify, delay, or deny services in a specified case under review, (the criteria shall) be disclosed to the provider and the enrollee in that specified case.

Citation Section 1367.01(h)(4)
Responses regarding decisions to deny, delay, or modify health care services requested by providers ...shall include a clear and concise explanation of the reasons for the plan's decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification.

Discussion: In the 14 UM denial files reviewed, all denial letters contained the following language: *" The guidelines that were used by Care 1st Health Plan (M & R) for your case are used by the Plan to authorize, modify or deny care for persons with similar illnesses or conditions."* Furthermore, all the letters included the language *"The materials provided to you are guidelines used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care or treatment may vary depending on individual needs and the benefits covered under your contract."* Additionally, there are no notations in either the handwritten case notes or the computerized notes indicating which criteria had been used and the specific criteria/criterion that is not met. The Plan's UM Policy 2.0.11 states *" the communication to the provider shall include the name and the telephone number of the healthcare professional responsible."* None of the 14 denial files reviewed had the printed name of the Chief Medical Officer or who made the determination as well as the telephone number of the medical officer. All the notices state, *"If you have questions, please contact Care 1st Member Services Department…"* This notice is not appropriate for the requesting providers. The Plan sends the same notice to the provider and the enrollee.

The same deficiencies were identified on the denial notices sent by the Plan's delegated IPAs/MGs.

Corrective Action 13: The Plan shall submit a corrective action plan that will provide consistent disclosure to the provider and the enrollee the criteria used as the basis of a decision to modify, delay, or deny services.

The Plan shall submit a corrective action plan that will provide for the inclusion of a direct number or an extension to allow the physician to easily contact the health care professional responsible for the denial, delay, or modification.

Plan's Compliance Effort: The Plan stated that it has already implemented the changes of the denial/modification letter to consistently include specific criteria used for making the

determination. The Plan further stated that the current denial/modification letters provide clear and concise explanations for the determinations, and copies of the clinical criteria that are used for determinations are attached to the letters. The copies of denial and modification letters provided by the Plan in response to the Preliminary Report for Deficiency 6 were also cited as attachments to this deficiency.

The Plan has added the Chief Medical Officer's phone number and extension under his signature on the denial/modification letters.

Department's Finding Concerning Plan's Compliance Effort:

Status: ***Not Corrected***

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department found that the Plan has not adequately demonstrated that it discloses to the provider and the enrollee the criteria used as the basis of a decision to modify, delay, or deny services.*

While the Plan did add the telephone and extension number of the Medical Director who signed the denial/modification letter and a copy of the applicable criteria is attached to the letter, the Plan still fails to describe the criteria used or clinical reasons for its denial decisions in its notification letters. Please see Department's response in Deficiency 6.

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

Deficiency 14: **The Plan's written responses to the providers and enrollees regarding decisions to deny, delay, or modify health care services do not include a clear and concise explanation of the reasons for the plan's decisions. The response does not also include a clear and easy to follow instruction as to how the enrollee may file a grievance with the Plan pursuant to Section 1368**. [Section 1367.01(h)(4)]

Citation: Section 1367.01(h)(4)
Responses regarding decisions to deny, delay, or modify health care services requested by providers ...shall include a clear and concise explanation of the reasons for the plan's decisions regarding medical necessity... Responses shall include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

Discussion: The Plan uses and sends the same "Notice of Denial, Deferral or Modification of Requests for Authorization" for both the provider and the enrollee. The Notice is poorly designed and not "enrollee-friendly." The decision is not presented at the beginning of the letter and the reasons for denial are written in a "technical language" that a layperson may not understand. Additionally, some of the copies of the denial notices submitted by the delegated IPAs to the Plan were not really denial notices, but rather, re-routing of the requests to the Plan because the Plan is financially responsible for payment of the service (e.g., durable medical

equipment of a certain dollar amount). Technically, these notices are not "denials" and should not involve, and further not sent to the enrollees. In such cases, the Plan and IPA should have a different process in place when the objective of the "re-route" is to instruct the provider where to file the claim.

The Notice of Denial contains instructions on how to file an appeal verbally or in writing. However, the instructions for filing an appeal with the Plan and requesting a Fair Hearing with the Department of Health Services are commingled. This makes it difficult for the reader to determine what is supposed to be filed, where it should be filed, and for what reason.

Corrective Action Plan 14: The Plan shall submit a corrective action plan that demonstrates that the Plan's written responses to the providers and enrollees regarding decisions to deny, delay, or modify health care services include a clear and concise explanation of the reasons for the Plan's decisions. The responses also must include clear and easy to follow instructions as to how the enrollee may file a grievance with the Plan pursuant to Section 1368.

Plan's Compliance Effort: The Plan stated that it has redesigned the denial/modification letter. The decision portion has been moved to the beginning of the letter with member identification, and the reasons for denial/ modification are written in simple language that a layperson can understand. Additionally, the letter contains separate headings for Plan's grievance process, Medi-cal Fair Hearing, DMHC, and IMR process.

The Plan has drafted a notice for IPAs to instruct them to discontinue sending denial notices to members in regard to services that are not IPA responsibility. The Plan will ask the IPA's to forward the request to Plan's UM Department directly. The Plan stated that once the draft letter is approved by the Compliance Department, the letter will be sent to all the delegated IPA's.

Department's Finding Concerning Plan's Compliance Effort:

Status: *Not Corrected*

The Plan has taken steps to remedy the deficiency as requested. However, full compliance was unable to be demonstrated within the 45-day response time.

Compliance Effort Discussion: *The Department reviewed the draft letter to IPA and found the contents to be appropriate. However, the Plan, by its own account, has not sent this letter out to the IPAs nor did it indicate the time frame when this letter will be distributed. The clarity of denial reasons remains an issue---please see the Department's response on related deficiencies 6 and 13.*

The Department will evaluate full implementation and effectiveness of the Plan's efforts to correct the deficiency during the Follow-up Review.

A P P E N D I X A

List of Surveyors

The Survey Team consisted of the following persons:

Department of Managed Health Care Representatives

Dan McCord, MBA	Associate Health Plan Analyst
Debra Burgess, RN, MHCA	Senior Health Plan Analyst

Managed Healthcare Unlimited, Inc. Representatives

Rose Leidl, RN, BSN	Project Manager
Bernice Young	Program Director
Lawrence Ikeda, MD	Quality Management Surveyor
Margaret Beed, MD, FAAP	Grievances and Appeals Surveyor
Ruth Martin, MBA, MPH	Utilization Management Surveyor
Patricia Beauvais, RN, MHSA	Access and Availability Surveyor
Martha Haynes, RN, MPH	Access and Availability Surveyor

A P P E N D I X B

Interview List

The following key Plan officers and staff were interviewed during the on-site survey at the Plan's administrative offices on August 27-30, 2001:

- Chairman & CEO
- Vice-President, Administration/Corporate Compliance Officer
- Chief Medical Officer
- Director, Medical Services
- Director of Pharmacy
- Quality Management Manager
- Manager, Member Service/Retention
- Manager, Utilization Management
- Supervisor, Credentialing

A P P E N D I X C

Provider Interview List

The following IPA/MGs, providers and staff were visited and interviewed during the on-site survey on August 27-30, 2001:

Asian Community Medical Group
Ms. Carol Houchins, President
Bao Le, MD, General Practice

Preferred IPA
Lilia Zamora, MD, Family Practice

Cal Care Medical Group
Fred Huizar, OD, Optometrist

University Affiliates IPA
Ronald Pitts, MD, Pediatrician

Crown City Medical Group
Ms. Maureen Tyson, CEO
Teddy King, MD, OB/GYN

A P P E N D I X D

Access to Care Standards

Criteria	Standard
Emergency exam	Immediately
Urgent PCP exam	Within 24 hours
Sensitive Services	Sensitive services must be made available to members preferably within 24 hours but not to exceed 48 hours of appointment request. Sensitive services are services related to: ▪ Sexual Assault ▪ Drug or alcohol abuse ▪ Pregnancy ▪ Family Planning ▪ Sexually Transmitted Diseases ▪ Outpatient mental health treatment and counseling Minors under 21 years of age may receive these services without parental consent. Confidentiality will be maintained in a manner that respects the privacy and dignity of the individual.
Routine PCP, Non-urgent exam	Within 7 Calendar Days
Initial prenatal visit to OB/GYN	Within 7 Calendar Days
Non-urgent specialist referral	Within 14 Calendar Days. Professional judgement and community standards will be expected to drive appointment decisions.
Well child visits (For child under 2 years of age)	Within 14 Calendar Days
Preventive care and physical exam	Within 30 Calendar Days
After-hours care	Physicians are required by contract to provide 24 hour, 7 days a week coverage to members. The same standards of access and availability are required by physicians "on-call".
Telephone Access	Physicians, or office staff, must return any non-emergency phone calls from members within 24 hours of the member's call. Urgent and emergent calls must be handled by the physician or his/her "on-call" coverage immediately. Clinical advice can only be provided by appropriately qualified staff (e.g.: physician, physician assistant, nurse practitioner or registered nurse).
Waiting Time in office	30 minutes maximum after time of appointment
Failed Appointments (Patient fails to show for a scheduled appointment)	Failed appointments must be documented in the medical record according to the provider's office's written policy and procedure with provisions for a case-by-case review of members with repeated failed appointments. Providers' offices are responsible for counseling such members.

A P P E N D I X D

Behavioral Health Access to Care Standards

Criteria	Standard
Life threatening/Emergency needs	Will be seen immediately
Non-Life threatening emergency needs	Will be seen within six hours
Urgent needs exam	Within 48 hours
Routine office visit, Non-urgent exam	Within 10 Calendar Days
After-hours care	Care 1st has RN's on-call 24 hours a day, 7 days a week to screen, triage and arrange behavioral health coverage to members. Care 1st utilizes the Department of Mental Health services at (800) 854-7771 to arrange care for any members that are a carve out for mental health benefits.
Telephone Access	Access by telephone for screening and triage is available 24 hours a day 7 days a week. Care 1st has RN's on-call at all times to arrange behavioral health coverage to members. Care 1st utilizes the Department of Mental Health services at (800) 854-7771 to arrange care for any members that are a carve out for mental health benefits.
Standard for reaching a behavioral health professional	Care 1st is available to arrange immediate access to a behavioral health professional through the Department of Mental Health's toll free hotline at (800) 854-7771.